

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037117
STATE FILE NUMBER

FILED NOV 14 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 362

5. 300
v. 1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hannibal</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth</u>			Length of stay in 1b		STREET ADDRESS <u>0644 5021 College Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Zilpha</u> Middle <u>Mirtle</u> Last <u>James</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>58</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 2 1877</u>		9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>8</u> Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Bladensburg Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Calvin McClain</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Coker</u>			14. NAME OF HUSBAND OR WIFE <u>Edward James</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Edward James Hannibal Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occluded Paraplegia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Alzheimer's & A.S.K.D.</u>				?	
			DUE TO (c) <u>Rheumatoid arthritis</u>				?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>Jan 1-58</u> to <u>Nov 2-58</u> and last saw her/him alive on <u>Nov 1-58</u> Death occurred at <u>12:40am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>[Address]</u>			22c. DATE SIGNED <u>11-4-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov 4 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Burial Park</u>		23d. LOCATION (City, town, or county) <u>Hannibal Ralls Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>W. Crawford Smith Hannibal Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-6-58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

RECEIVED NOV 12 1958

MARION CO. HEALTH DEPT.

DATE FILED NOV 12 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student Signature of Student Embalmer

Signed *H. Crawford Smith*

Licensed Embalmer No. 3814

P. O. Address..... Hannibal, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.